No. 14-181

In The
Supreme Court of the United States

ALFRED GOBEILLE, in his official capacity as chair of the Vermont Green Mountain Care Board,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

BRIEF OF *AMICUS CURIAE* CONNECTICUT HEALTH INSURANCE EXCHANGE D/B/A ACCESS HEALTH CT IN SUPPORT OF PETITIONER

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INTEREST OF *AMICUS CURIAE*

The Connecticut Health Insurance Exchange d/b/a Access Health CT (the Exchange)[1] is the health insurance exchange for the State of Connecticut. The Exchange is a quasi-public agency tasked with, among other things, the development and operation of Connecticut's all-payer claims database (the APCD). *See* Conn. Gen. Stat. § 38a-1081.

In *Liberty Mutual Insurance Company v. Donegan*, 746 F.3d 497 (2d Cir. 2014), a divided panel of the Second Circuit Court of Appeals held that the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 *et seq.*, preempts health care data reporting laws, including all-payer claims databases, with respect to self-insured health insurance plans subject to ERISA. The decision of the Court of Appeals is a direct threat to the Exchange's ability to fulfill its statutory mandate and, unless overturned, may act to limit Connecticut's access to

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[1] All parties to this matter have granted blanket consent for the submission of *amicus curiae* briefs in support of either or neither party. The petitioner filed his consent on July 9, 2015, and the respondent filed its consent on July 10, 2015. The requirements of Rule 37.2(a) of the Rules of this Court are satisfied by these filings. In accordance with Rule 37.6, *amicus curiae* affirms that no counsel for a party authored this brief in whole or in part, and represents that no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person or entity other than the *amicus curiae*, its members or its counsel, has made a monetary contribution to the preparation or submission of this brief.

essential health care information. The Exchange maintains that this decision was in error and misapplies ERISA preemption to health care laws in an overly broad manner that threatens the ability of Connecticut to collect health care information for the purpose of improving the quality, efficiency and accessibility of health care services in Connecticut.

SUMMARY OF ARGUMENT

At issue in this case is whether States may require payers of health care services, specifically self-insured health insurance plans governed by ERISA, to provide the State with health care claims data that the State has deemed essential to its efforts to address health care policy and implement health care reform initiatives.

The purpose and history of State APCD efforts reflect that they fall squarely within the legitimate realm of traditional State policing authority in an area that is firmly within the provenance of the States. The crucial State interests at stake in these efforts will be substantially undermined if the decision of the Court of Appeals is upheld.

This Court's decisions on ERISA preemption establish that State efforts to regulate health care through laws of general applicability that do not purport to regulate the structures or core functions of ERISA plans are not preempted by ERISA. The Court of Appeals inappropriately rejected the presumption

against preemption, and its decision manifests a much broader view of preemption that undermines the legitimate health care policy objectives of the States.

ARGUMENT

I. The Connecticut APCD Statute is an Exercise of Connecticut's Traditional Police Power to Address Health Care Issues, and the Decision Below Threatens to Seriously Diminish the Effectiveness of Such Exercise.

A. The Connecticut APCD Statute is a Law of General Applicability that Addresses Health Care Issues.

Connecticut's "all-payer claims database" is a database that "receives and stores data from a reporting entity relating to medical insurance claims, dental insurance claims, pharmacy claims and other insurance claims information from enrollment and eligibility files." Conn. Gen. Stat. § 38a-1091(a)(1). The APCD receives such claims information from, among other entities:

> (A) insurers licensed to do health insurance business in Connecticut;
>
> (B) third-party administrators;
>
> (C) pharmacy benefits managers;

(D) fraternal benefit societies that transact health insurance business in Connecticut;

(E) dental plan organizations;

(F) preferred provider networks; and

(G) "[a]ny other person that administers health care claims and payments pursuant to a contract or agreement or is required by statute to administer such claims and payments." *Id.* § 38a-1091(a)(2)(A).

One key purpose of collecting health care claims data is to allow the APCD to utilize such data "to provide health care consumers in the state with information concerning the cost and quality of health care services that allows such consumers to make economically sound and medically appropriate health care decisions." *Id.* § 38a-1091(b)(4)(A). In addition, the APCD will make de-identified[2] health care claims information available to State agencies, insurers, employers, health care providers, consumers of health care services, and researchers "for the purpose of allowing such person or entity to review such data as it relates to health care utilization, costs or quality of health care services." *Id.* § 38a-1091(b)(4)(B).[3]

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[2] De-identified health care information is information from which all eighteen identifiers enumerated at 45 C.F.R. § 164.514(b)(2) have been removed.

[3] For example, oncology researchers may link claims data with tumor registry data (for cancer stage information) and vital

(Continued on following page)

The APCD may also make such information available for community and public health assessment activities.[4] Thus, health care researchers and policy makers may be granted access to health care claims information to identify disparities, or more specifically, income classes or racial demographic groups lacking access to certain categories or types of health care services. State regulators may be granted access to the information when making health care planning decisions, such as the review of Certificate of Need[5] applications by the Connecticut Department of Public Health.[6] Consumers may be granted access to the health care claims information to compare the

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statistics data (for information on death) currently maintained by the State. This connectivity may contribute to a better understanding of the efficacy of various treatment modalities. Generally, studies of cancer and rare diseases benefit from the use of large underlying population data in order to provide reasonable size for longitudinal studies. If claims data from self-insured plans is excluded, it would limit the ability of researchers to conduct such important studies.

[4] Policies and Procedures: All-Payer Claims Database, Connecticut Health Insurance Exchange, adopted Dec. 5, 2013, available at http://www.ct.gov/hix/lib/hix/DRAFT_AHCT_APCD_Policies_and_Procedures.pdf (accessed Aug. 27, 2015).

[5] In many instances, Connecticut law requires a health care provider to submit a Certificate of Need application to the Department of Public Health prior to opening or closing a facility or service line. Conn. Gen. Stat. § 19a-638.

[6] The Department of Public Health, through its Office of Health Care Access, utilizes the Certificate of Need process as a mechanism to restrain health care facility costs and allow coordinated planning of new health care services and construction. Conn. Gen. Stat. § 19a-639.

costs of receiving a particular treatment or service at various local health care providers. Lastly, the information may be useful in the development of wellness and disease prevention programs.

The APCD also is integral to Connecticut's participation in the State Innovation Model (SIM) program established by the Centers for Medicare and Medicaid Services (CMS). In 2014, CMS awarded Connecticut a four-year, $45 million grant to "test state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries – and for all residents."[7] The APCD has been identified as a key resource for the implementation of this program in Connecticut,[8] and the APCD's inability to receive claims data from self-insured health plans would undermine the success of the program.

The value and importance of the APCD with respect to consumer health care education and the reform of health care in Connecticut with respect to

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[7] SIM Program Management Office, Connecticut State Innovation Model: SIM at a Glance, May 12, 2015, available at http://www.healthreform.ct.gov/ohri/lib/ohri/SIM_at_a_glance_05122015.pdf (accessed Sept. 1, 2015).

[8] Office of the Lieutenant Governor, Connecticut Healthcare Innovation Plan, Dec. 30, 2013, available at http://www.healthreform.ct.gov/ohri/lib/ohri/sim/plan_documents/ct_ship_2013_12262013_v82.pdf (accessed Sept. 1, 2015).

health care utilization, costs, and quality of health care services has been recognized and endorsed by a diverse set of stakeholders in Connecticut's health care community. In public comments, the Connecticut State Medical Society[9] recognized the importance of the APCD in addressing issues of health care access and disparity based upon income, racial or other demographic factors and stated "[d]ata collection is the best means we have to analyze how we as a state are doing when it comes to breaking down racial and ethnic barriers in healthcare."[10] Echoing the Connecticut State Medical Society's emphasis on health care access and disparity, the Connecticut Health Foundation[11] stated that the APCD "has the potential to help answer timely and relevant access, quality, and cost questions about coming health care reforms" and "will be tremendously useful" with respect to the foundation's health equity and integrated care concerns.[12]

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[9] The Connecticut State Medical Society is the professional association for physicians practicing in Connecticut.

[10] Comments on Draft Policies and Procedures: All-Payer Claims Database, Connecticut State Medical Society, Sept. 9, 2013, available at http://www.ct.gov/hix/lib/hix/APCD_Policies_and_Procedures_Public_Comments_-_CT_State_Medical_Society.pdf (accessed Aug. 27, 2015).

[11] The Connecticut Health Foundation is a private foundation working to creating more access to better quality health care for populations of color and underserved communities in Connecticut.

[12] Public Comment, APCD Draft Policies and Procedures and Data Submission Guide, Connecticut Health Foundation, Sept. 3, 2013, available at http://www.ct.gov/hix/lib/hix/APCD_Policies_and_Procedures_Public_Comments_-_CT_Health_Foundation.pdf (accessed Aug. 27, 2015).

Stakeholders have also noted the importance of the APCD to improving the quality of health care in Connecticut. The Connecticut Business & Industry Association[13] noted that the APCD is "a tool that stakeholders throughout the state may utilize to gain information on healthcare costs and quality with the goal of enhancing outcomes and improving efficiency."[14] The State of Connecticut Comptroller[15] referred to the APCD as a "significant and important tool for improving the efficiency and outcomes in our health care system."[16] Similarly, in joint comments, the Connecticut Center for Patient Safety[17] and the Connecticut Health Policy Project[18]

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[13] The Connecticut Business and Industry Association is a statewide business organization.

[14] Comment in Response to Access Health CT's Draft Policies and Procedures: All-Payer Claims Database, Connecticut Business & Industry Association, Sept. 12, 2013, available at http://www.ct.gov/hix/lib/hix/APCD_Policies_and_Procedures_Public_Comments_-_CT_Business_and_Industry_Association.pdf (accessed Aug. 27, 2015).

[15] The State of Connecticut Comptroller is a state agency with responsibility for fiscal and government transparency matters, including affordable and quality health care.

[16] Comments of State of Connecticut Comptroller, Sept. 12, 2013, available at http://www.ct.gov/hix/lib/hix/APCD_Policies_and_Procedures_Public_Comments_-_Comptroller_Kevin_Lembo.pdf (accessed Aug. 27, 2015).

[17] The Connecticut Center for Patient Safety is a nonprofit organization focused on patient safety, the quality of health care services and patient rights.

[18] The Connecticut Health Policy project is a nonprofit research and educational organization working to improve access to affordable, quality health care for Connecticut residents.

noted the potential of the APCD "to improve health care planning, control costs, improve the quality of care, and reduce health disparities."[19]

B. The History of the Connecticut APCD Statute Makes Clear that it Addresses Health Care Issues, and Reflects the Focus of Constituents in the Health Care Industry to Address Health Care Issues.

The history of Connecticut's APCD underlines its purpose as a tool to inform the effective and informed regulation of the health care industry, a traditional and long-accepted role for State government. In 2011, and in response to the passage of the Patient Protection and Affordable Care Act, P.L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152, 124 Stat. 1029, and nationwide efforts to reform the delivery of health care to improve efficiency, quality and utilization, the State of Connecticut created the Office of Health Reform and Innovation (OHRI). *See* 2011 Conn. Acts 11-58 §§ 11, 13. The OHRI was housed in the Office of the Lieutenant Governor and was tasked with coordinating and implementing

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[19] Comments of Connecticut Center for Patient Safety and the Connecticut Health Policy Project, Sept. 10, 2013, available at http://www.ct.gov/hix/lib/hix/APCD_Policies_and_Procedures_Public_Comments_-_Ellen_Andrews_and_Jean_Rexford.pdf (accessed Aug. 27, 2015).

Connecticut's "responsibilities under state and federal health care reform." *Id.* § 13. Among other things, the OHRI was directed to develop "a plan to implement a state-wide multipayer data initiative to enhance the state's use of health care data from multiple sources to increase efficiency, enhance outcomes and improve the understanding of healthcare expenditures in the public and private sectors." *Id.* § 11.

In 2012, the Connecticut General Assembly formally established the APCD, resulting from the "multipayer data initiative." 2012 Conn. Acts 12-166 § 1. This act established the requirements for reporting entities to submit data to the APCD and the uses of the claims data for the benefit of consumers, the State, and other stakeholders as described in Section I.A., above. Responsibility for the establishment and implementation of the APCD was transferred to the Exchange in 2013. 2013 Conn. Acts 13-247 §§ 137, 144. The health care purpose and mission of the program remained unchanged as a result of the transfer.

The Exchange's development and implementation of the APCD has been supported and guided by the All-Payer Claims Database Advisory Group (the Advisory Group). Conn. Gen. Stat. § 38a-1091(c)(1). The Advisory Group is composed of: (i) the Secretary of the Office of Policy and Management; (ii) the Comptroller; (iii) the Commissioners of the Departments of Public Health, Social Services, Mental Health and Addiction Services, and Insurance; (iv) the Healthcare Advocate; (v) the Chief Information

Officer of the State of Connecticut Department of Information Technology; and (vi) representatives of the Connecticut State Medical Society, health insurance companies, consumers, hospitals, consumer advocates and health care providers. *Id.* The purpose of the Advisory Group is to assist the APCD in enhancing the "state's use of health care data from multiple sources to increase efficiency, enhance outcomes and improve the understanding of health care expenditures in the public and private sectors." *Id.* § 38a-1091(c)(2). The Advisory Group meets quarterly to review APCD activities, to provide stakeholder feedback, and to review operating policies and procedures in order to make recommendations to the Exchange's board of directors. The APCD relies upon the Advisory Group members, including representatives of health insurance companies, to improve the effectiveness of the APCD and address stakeholder concerns.

C. The Decision Below may Seriously Diminish the Effectiveness of Connecticut's APCD.

The decision of the Court of Appeals puts at risk Connecticut's APCD and, by implication, Connecticut's health care reform efforts. The decision threatens to weaken one of Connecticut's most powerful tools for reviewing and analyzing health care data and would hamper Connecticut's ability to promulgate evidence-based health care policy and regulation.

The decision is also a threat to health care reform more broadly if it applies to all similar all-payer claims database statutes. At least sixteen States have enacted legislation establishing such health care data programs, and numerous other States have expressed interest in adopting similar programs.[20] This trend reflects the reality that effective health care reform and innovation efforts are predicated on access to accurate and complete data. Affirming the Second Circuit's expansive view of ERISA preemption would result in a firewall being imposed on self-insured health insurance plan claim information. This will have a devastating impact on the States' efforts. In Connecticut, in 2011, 54.4% of workers who obtain health insurance coverage through their employer were enrolled in a self-insured plan, and the percentage of workers enrolled in such plans has continued to grow.[21] In many instances, the data maintained by health plans cannot be obtained from other sources. A decision that prevents health care policymakers and regulators from collecting health care claims information from such a large segment of the population would therefore severely frustrate the continued

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[20] Rebecca Paradis & Erin Bartolini, *All Payer Claims Databases: Unlocking the Potential*, NEHI Issue Brief (Network for Excellence in Health Innovation, Cambridge, MA), Dec. 2014, at 1.

[21] Paul R. Fronstin, *Self-Insured Health Plans: State Variation and Recent Trends by Firm Size*, 33 EBRI.ORG Notes (Employee Benefit Research Institute Educ. & Research Fund, Washington, DC), Nov. 2012, at 1, 6.

movement towards evidence-based health care reform and innovation efforts.

II. The Vermont APCD Statute and Similar State Statutes are not Preempted by ERISA.

The Vermont APCD statute, and similar APCD statutes, including the Connecticut APCD statute, are not preempted by ERISA because they are not State laws that relate to employee benefit plans within the scope of ERISA's preemption clause, 29 U.S.C. § 1144(a).

This Court has held that, despite the "clearly expansive" preemption language employed by ERISA, there remains a presumption that Congress did not intend to supplant State law, particularly where the State is acting within a field of traditional State regulation. *N.Y. Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995). The Court of Appeals rejected this presumption because it held that Vermont's statute did "not regulate the safe and effective provision of health care services." *Donegan*, 746 F.3d at 506 n.8. This view is blind to the goals of APCDs and casts aside the paramount State interest in data collection endeavors, which as seen above with regard to Connecticut's efforts, is directly related to improving quality, enhancing access, and achieving efficiencies in the provision of health care services.

Given the intended purposes of APCD statutes like Vermont's, and as detailed above regarding

Connecticut's efforts, there can be no question but that such APCDs advance the legitimate interests of the States in regulating "matters of health and safety." *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997).

The Court of Appeals concluded that the Vermont law was preempted because it required "reporting," which "is a core ERISA function." *Donegan*, 746 F.3d at 508. In adopting this literal view of the word "reporting," however, the Second Circuit failed to account for the vast difference in context of the ERISA reporting requirements. Instead, it fell victim to the same predicament that this Court identified in *Travelers* when it observed that as a phrase of limitation, the phrase "relate to" in 29 U.S.C. § 1144(a), read literally, was not helpful. *See Travelers*, 514 U.S. at 655 ("If 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course . . . ."). In a similar way, the word "reporting," read literally by the Court of Appeals as "filing with a third party," *Donegan*, 746 F.3d at 508, would put all manner of general purpose health care laws at risk of preemption simply because a third-party filing must be made, regardless of whether it impacted the core concerns of ERISA.

The District Court, in sharp contrast, recognized the importance of context in this Court's ERISA jurisprudence:

> The appropriate question . . . is not the uncritically literal one of whether Vermont's health care database law imposes a reporting requirement on . . . an ERISA plan. It is rather a more contextual one: whether a state data reporting requirement dictates or disrupts the activities or operations of an ERISA plan, or compromises the administrative integrity of an ERISA plan, or in some way creates state oversight of the administration of an ERISA plan.

Liberty Mut. Ins. Co. v. Kimbell, No. 2:11cv204, 2012 WL 5471225, at *12 (D. Vt. Nov. 9, 2012). The District Court went on to conclude, correctly, that the Vermont statute did not dictate benefits or disrupt the activities or operations of an ERISA plan and that it, therefore, was not preempted. *See id.* at *13.

The decision of the Court of Appeals is inconsistent with this Court's approach to preemption in *Du Buono* and *Travelers*. The presumption against preemption in these circumstances should not be overcome where a State law of general applicability does not relate to ERISA plans in any meaningful way, such as by dictating benefits or interfering with plan administration.

The States should be free to pursue their legitimate interests in obtaining the information deemed necessary to regulate and improve the provision of health care services to their citizens and to empower their citizens to actively participate in the health care decision-making process. The decision of the Court of

Appeals, if not reversed, will put at risk the effectiveness of not only the Vermont APCD statute, but all similar APCD statutes.

CONCLUSION

For the foregoing reasons, *Amicus* respectfully urges this Court to reverse the decision of the Second Circuit Court of Appeals.

Respectfully submitted,

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